STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	535049	A. Building B. Wing	10/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Casper	4041 South Poplar Street Casper, WY 82601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 35081 Based on observation, resident and staff interview, grievance review, and policy and procedure review, the facility failed to ensure residents were treated with dignity and respect on 1 of 2 resident units (unit 1). The census was 81. The findings were: 1. Interview with 9 residents during resident council on 10/15/24 at 10:40 AM revealed at times residents had to wait between 45 minutes and 2 hours for call lights to be answered. The residents revealed they had observed staff walking by rooms or sitting at the nurses' station while call lights were sounding. Further interview revealed the number of staff answering call lights during the survey was increased compared to the number of staff who normally answered call lights. 2. Observation on 10/16/24 at 9:35 AM showed the call light for resident #20 was turned on. Continued observation until 9:48 AM showed 18 staff members passed by the resident's room. The staff included 3 activities staff members, 4 CNAs, an LPN, and 2 laundry staff members which walked past the resident's room a total of 18 times without entering the resident's room or offering assistance. At 9:49 AM LPN #1 entered the resident's room to answer the call light and asked if she could assist the resident. At that time, the resident stated they forgot to shut it off. 3. Observation on 10/16/24 showed the call light for resident #72 was turned on for 42 minutes from 9:55 AM to 10:37 AM. Further observation showed staff walked past the resident's room without entering to assist the resident. 4. Review of a Concern & Comment Form dated 3/20/24 showed resident #11 reported on 3/19/24 his/her call light was on from 6:45 AM to 9 AM and the resident expressed frustration with call light times (outside of this one event). Review of a Concern & Comment Form dated 5/18/24 showed the resident reported Call lights taking too long to be answered. Review of a Concern & Comment Form dated 7/15/24 showed the resident reports frustration with call light response times. [S/He] states they are taking 1 to 1 1/2 hours to be answered, especially around 6:30 AM. Reports nursing won't help answer them and defer to the aide to need to help instead. Reports [s/he] filled out a previous card re: [regarding] this with no improvement. 5. Interview with the DON on 10/17/24 at 10:19 AM revealed everyone was expected to answer call lights and the lights should be answered between 3 and 5 minutes for an emergency light or 5 and 7 minutes for a regular light. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. Review of the policy titled Resident Call System, last revised 1/4/2023, showed .Procedure: 1. Facility associates should always be aware of call lights. 2. Associates should answer call lights whether they are assigned to provide care to that resident .

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 37220 Based on medical record review, staff interview, and review of the MDS 3.0 RAI (Resident Assessment Instrument) manual, the facility failed to ensure a significant change assessment was completed for 1 of 18 (#35) sample residents. The findings were: 1. Review of the medical record for resident #35 showed s/he had fallen on 3/20/24 which resulted in a fractured hip. Review of the 3/26/24 significant change MDS assessment showed the resident was coded as dependent for toileting hygiene, lower body dressing, putting on and taking off footwear, toilet transfers, and tub/shower transfers. The resident was coded as requiring substantial/maximal assistance for showering or bathing self, personal hygiene, rolling left to right, sitting to lying, sitting to standing, and chair/bed-to-chair transfers. In addition, the resident was coded as requiring partial/moderate assistance for eating, oral hygiene, upper body dressing, lying to sitting, and moving a manual wheelchair. The resident was not assessed for walking due to safety reasons. 2. Review of the 9/11/24 quarterly MDS assessment showed the resident was coded as being independent with moving his/her manual wheelchair and rolling left and right. The resident required setup or clean-up assistance for eating, oral hygiene, toileting hygiene, and personal hygiene. The resident was coded as requiring supervision or touching assistance for upper body dressing, sitting to lying, lying to sitting, sitting to standing, chair/bed-to-chair transfers, and could walk for 150 feet. 3. Interview with MDS coordinator on 10/17/24 at 10:07 AM confirmed a significant change assessment had not been completed. 4. Review of the CMS RAI 3.0 User's Manual, October 2023, showed .03. Significant change in status assessment (SCSA) (A0310A=04) The SCSA is a comprehensive assessment for a resident that must be completed when the IDT (interdisciplinary team) has determined that a resident meets the significant change guidelines for either major improvement or decline .An SCSA is appropriate if there are either two or more areas of decline or two or more areas of improvement .Improvement in two or more of the following: Any improvement in an ADL (activities of daily living) where a resident is newly coded as Independent, setup or clean-up assistance, or supervision or touching assistance which last assessment and does not reflect normal fluctuations in that individual's functioning .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37220 Based on medical record review, staff interview, and review of the RAI (resident assessment instrument) manual, the facility failed to ensure MDS assessments were accurately completed for 3 of 5 (#34, #35, #71) sample residents reviewed for falls. The findings were: 1. Review of a 5/4/24 Event Note showed resident #34 had a witnessed fall with bilateral knee soreness, pain to the right lateral thigh, and bruising to the left knee and right lateral thigh. Review of a 6/15/24 Event Note showed the resident had an unwitnessed fall and had no signs or symptoms of pain or distress. The following concerns were identified: a. Review of 5/15/24 and 8/13/24 quarterly MDS assessments showed the resident was coded as not having any falls since admission or the prior assessment. 2. Review of a 3/20/24 Event Note showed resident #35 had an unwitnessed fall and was transported to the emergency department for evaluation. Further review of the medical record showed the resident had fractured his/her left hip. The following concerns were identified: a. Review of the 3/26/24 significant change MDS assessment showed the resident was coded as not having any falls since admission or the prior assessment. 3. Review of the medical record showed resident #71 was admitted on [DATE]. Review of Event Notes from 4/26/24, 6/23/24, and 8/27/24 showed the resident had unwitnessed falls with no injury noted. The following concerns were identified: a. Review of the 6/6/24 and 9/5/24 quarterly MDS assessments showed the resident was coded as not having any falls since admission or the prior assessment. 4. Interview with the MDS coordinator on 10/17/24 at 10:51 AM confirmed falls were incorrectly coded on the MDS assessments. 5. Review of the CMS RAI 3.0 User's Manual, October 2023, showed .Determine the number of falls that occurred since admission/entry or reentry or prior assessment and code the level of fall-related injury for each. Code each fall only once. If the resident has multiple injuries in a single fall, code the fall for the highest level of injury.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35081 Based on medical record review, staff interview, and policy and procedure review, the facility failed to ensure as needed (PRN) psychotropic medication was limited to 14 days or the physician provided a rationale for extended use for 1 of 5 sample residents (#43) reviewed for unnecessary medications. The findings were: 1. Review of the physician orders for resident #43 showed the resident had an order for lorazepam (antianxiety) 0.5 milligrams to be given every 2 hours as needed for anxiety and restlessness related to end of life care ordered on 8/16/24 and no stop date. The following concerns were identified: a. Review of a progress note dated 10/17/24 and timed 9:33 AM showed Per [RN name] with Dr. [name] re: [regarding] Lorazepam usage: The dx [diagnosis] palliative care for its use of Lorazepam is for [facility] comfort care and the behavior could occur at any time and so its [sic] for the benefit of the patient. The benefit outweighs the risk of continuing the medication for the life of resident. 2. Interview with the DON on 10/17/24 at 10:19 AM confirmed the facility did not have a stop date or rationale for the lorazepam prior to 10/17/24. 3. Review of the facility policy titled Psychotropic Medication Use last revised on 11/28/16 showed .5. PRN orders for psychotropic drugs should be limited to 14 days. If the attending physician or prescribing practitioner believes that it is appropriate for the order to be extended beyond 14 days, he or she should document their rationale in the resident's record and indicate the duration for the PRN order .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 50665 Based on observation, medical record review, staff interview, and policy and procedure review, the facility failed to establish and maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections for 2 of 2 resident units. This failure affected resident #30, #50, #52, #67, and #73. The census was 81. The findings were: 1. Review of the 8/23/24 quarterly MDS assessment for resident #30 showed s/he had a suprapubic catheter and a diagnosis of neurogenic bladder. Observation on 10/16/24 at 9:44 AM of the resident's room showed no EBP (enhanced barrier precautions) signage or PPE (personal protective equipment) was present. 2. Review of the 8/21/24 admission MDS assessment for resident #50 showed s/he had a suprapubic catheter with a diagnosis of progressive neurological conditions. Observation on 10/16/24 at 9:44 AM of the resident's room showed no EBP signage or PPE was present. 3. Review of the Order Summary Report for resident #52 showed s/he had an indwelling catheter, a PICC (peripherally inserted central catheter) line for receiving antibiotics, and required wound care to his/her left heel. Observation on 10/14/24 at 2:17 PM, 10/15/24 at 9:23 AM, and 10/16/24 at 11:50 AM of the resident's room showed no EBP signage or PPE was present. 4. Review of the 9/20/24 admission MDS assessment for resident #67 showed the resident had a stage 3 decubitus ulcer to the coccyx which required routine wound care. Observation on 10/16/24 at 9:44 AM of the resident's room showed no EBP signage or PPE was present. 5. Observation on 10/15/24 at 1:35 PM showed RN #1 was performing wound care on resident #73 using gloves; however, the RN was not wearing a gown. Further observation of the room showed EBP signage was on the wall and PPE was hanging on the inside of the resident's door; however, no gowns were present. 6. Interview with RN #1 on 10/15/24 at 2:02 PM revealed resident #73 was no longer on EBP because his/her PICC line had been removed. In addition, EBP was only indicated for residents with Foley catheters, lines, or wounds with multi drug resistant organisms (MDRO). 7. Interview with the infection preventionist (IP) on 10/15/24 at 2:06 PM revealed EBP were used when residents have Foley catheters, lines, or MDRO wounds. Further, resident #73 was removed from EBP due to his/her PICC line being removed. An additional interview on 10/16/24 at 9:35 AM with the IP revealed residents on EBP were identified with a pink star on their room number/name plate, EBP signage should be present in the room, and PPE available. 8. Review of the policy and procedure Enhanced Barrier Precautions, revised 3/21/24, showed .the indications for EBP are for residents with wounds and or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.